

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 3:125, Chiropractic Services and Reimbursement

Summary of Material Incorporated by Reference

The Ky. Form MAP-810, Chiropractic Prior Authorization Form, September 26, 2000 edition, is used by agency staff and participating providers. The form contains one (1) **page**.

907 KAR 3:125
Incorporation By Reference

KY Form MAP-810, Chiropractic Prior
Authorization Form
September 26, 2000 Edition

Filed December 2000

Chiropractic Prior Authorization Form

Recipient/Patient: _____ MAID #: _____ Date of Birth: ____/____/____
 Complaint(s): _____ @New Episode ☒ Continuing Care
 Date of Onset: ____/____/____ Mechanism of Onset: _____
 Other Treatment & Medications received: _____
 Complications: _____

Patient Section: On the blank line in the left hand column, write in each area of complaint (example: neck, low back), then...
 For Continuing Care after 12 visits, please complete all. For new episode after 12 visits, **please mark** Pain Scale and Remarks only.

	<input type="checkbox"/>	Improved	CI	Same	CI	Worse	Pain Level (O-10) = _____	Remarks: _____
	<input type="checkbox"/>	Improved	<input type="checkbox"/>	Same	CI	Worse	Pain Level (O-10) = _____	Remarks: _____
	<input type="checkbox"/>	Improved	<input type="checkbox"/>	Same	CI	Worse	Pain Level (O-10) = _____	Remarks: _____
	<input type="checkbox"/>	Improved	<input type="checkbox"/>	Same	<input type="checkbox"/>	Worse	Pain Level (O-10) = _____	Remarks: _____
	<input type="checkbox"/>	Improved	CI	Same	<input type="checkbox"/>	Worse	Pain Level (O-10) = _____	Remarks: _____
	<input type="checkbox"/>	Improved	<input type="checkbox"/>	Same	<input type="checkbox"/>	Worse	Pain Level (O-10) = _____	Remarks: _____

Provider Section: Date of 1st Exam: ____/____/____ (if continuing care requested) Date of this exam: ____/____/____

Cervical Range of Motion:

Initial Exam	Degree	Sharp Pn	Dull Pn	Notes	Current Exam	Degree	Sharp Pn	Dull Pain	Notes
Flexion	/50	L M R	L M R		Flexion	/50	L M R	L M R	
Extension	/70	L M R	L M R		Extension	/70	L M R	L M R	
Rt Rotation	/85	L M R	L M R		Rt Rotation	/85	L M R	L M R	
Lt Rotation	/85	L M R	L M R		Lt Rotation	/85	L M R	L M R	
Rt Side Bend	/45	L M R	L M R		Rt Side Bend	/45	L M R	L M R	
L t Side Bend	/45	L M R	L M R		L t Side Bend	/45	L M R	L M R	

Lumbar Range of Motion:

Initial Exam	Degree	Sharp Pn	Dull Pn	Notes	Current Exam	Degree	Sharp Pn	Dull Pn	Notes
Flexion	/90	L M R	L M R		Flexion	/90	L M R	L M R	
Extension	/30	L M R	L M R		Extension	/30	L M R	L M R	
Rt Side Bend	/35	L M R	L M R		Rt Side Bend	/35	L M R	L M R	
Lt Side Bend	/35	L M R	L M R		Lt Side Bend	/35	L M R	L M R	

Orthopedic and Other Tests:

Initial Exam	Sharp Pn	Dull Pn	Location of Pain	Current Exam	Sharp Pn	Dull Pain	Location of Pain

Treatment Modalities and Procedures with Goals: (# means number of each CPT requested, Goals means specific goal for that CPT code)

CPT Code	#	Goals	CPT Code	#	Goals

Imaging Findings (Xray, MRI, etc): _____
 Additional Comments: _____
 Diagnosis Codes: _____

Additional Visits and Weeks Requested: *Continuing:* visits/ _____ weeks OR *New:* visits/ _____ weeks

Provider: _____ Provider #: _____, D _____/_____/_____.

Provider Telephone: _____ Fax: _____ Signed: _____

For HRC Office Use Only: Completed Plan Approved? Yes No PA Number: _____

Mail to: Healthcare Review Corporation Or FAX to : 502-429-5233
 9200 Shelbyville Rd., Suite 800
 Louisville KY 40222-8504

(Please attach any pertinent additional documentation)